Illinois Department of Healthcare and Family Services

HOSPITAL, PROFESSIONAL SCHOOL OR PRACTITIONER OWNED GROUP PRACTICE AS ALTERNATE PAYEE

1) The practitioner certifies that he or she is: a) an employee of the hospital or professional school or practitioner owned group practice and must, as a condition of his or her employment, turn over his or her fee for care or service to Healthcare and Family Services recipients to the hospital, school, or group practice; OR, b) an independent contractor under contract with the hospital and under the terms of that contract, the hospital submits the claims to the Department.

2) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice that, all owners, directors, members or practitioners of the group practice are licensed and eligible to participate, and at this time of application are in good standing in the Medical Assistance Program of Healthcare and Family Services.

3) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice, that the group practice shares facilities, equipment and personnel and maintains central patient records.

4) If this form is used for a hospital or school, no bills submitted by the practitioner are for services for which reimbursement has been made to the hospital or school or for which reimbursement will be sought by submission of a cost report, invoice or otherwise.

5) Bills submitted will only be for direct patient care rendered or supervised by that practitioner; e.g., services for which the practitioner assumes full responsibility as specified in Provider Handbooks.

6) The hospital, school or group practice shall be responsible for maintaining and making available to the Department all business and professional records sufficient to fully and accurately document the nature, scope, detail and receipt of services provided to Healthcare and Family Services recipients by the provider for whom this form has been submitted. The hospital, school or group practice shall be responsible for retaining such records for the period required under 89 Illinois Administrative Code 140.28, even if practitioner leaves the employ or otherwise terminates his or her relationship with the hospital, school or group practice.

7) The hospital, school or group practice will keep and make available to Healthcare and Family Services such records regarding any payments claimed by the hospital, school or group practice for providing services to Healthcare and Family Services recipients as the Department may request.

8) The hospital, school or group practice will keep and make available all financial records that may be requested by Healthcare and Family Services, specifically including records that set forth the terms of the relationship between the hospital, school, or group practice and its practitioners.

9) The hospital, school or group practice shall have sole financial responsibility for any bills submitted in the name of the practitioner for which it is the alternate payee. However, if the practitioner owns, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporate hospital, school or group practice, or is an investor, owner or partner of the hospital, school, or group practice, the practitioner and the hospital, school or group practice are jointly and severally liable and responsible. This responsibility includes liability to repay any overpayments made by the Department. By signing this form the hospital, school, or group practice expressly authorizes Healthcare and Family Services to withhold overpayments from payments made by the Department, either as direct payments to the hospital, school, or group practice or made based on the hospital, school, or group practice being an alternate payee.

10) In the event the alternate payee designated on this form is not a licensed hospital, professional school or practitioner owned group practice, both the practitioner and the alternate payee designated understand and acknowledge that they shall be personally liable and responsible, jointly and severally, for any bills submitted to Healthcare and Family Services even though such bills were prepared, signed and/or submitted solely by the alternate payee or the alternate payee's agent. Liability hereunder shall include any civil and/or criminal liability, including but not limited to liability under the theory of accountability and liability for repayment of any overpayment received by the designated alternate payee, plus any penalty provided by statute.

11) The practitioner shall be responsible for the accuracy and truthfulness of all bills submitted on behalf of the practitioner. Bills submitted in the practitioner's name will be signed by him or her personally or by an authorized agent pursuant to a power of attorney. This power of attorney must be executed on Form HFS 2306 which shall be submitted to the Department prior to submittal of any bills signed by the agent. Practitioner understands and acknowledges that it is his or her personal responsibility to review any and all billings before such billings are submitted to Healthcare and Family Services on practitioner's behalf and/or in his or her name.

12) The parties signing this document acknowledge and agree that payments will be directed to the alternate payee for all dates of service beginning _____ and thereafter (insert date no earlier than sixty days prior to submission of this document to the Department).

Illinois Department of Healthcare and Family Services

CERTIFICATION
The parties to this agreement hereby certify under penalty of perjury that they are in compliance with 89 Illinois Administrative Code, Section 140.24 (d), in that: a) The medical practitioner has a contractual/salary arrangement, as a condition of employment with a hospital or professional school; b) The medical practitioner is part of a practitioner owned group practice consisting of three or more fulltime licensed practitioners or the equivalent thereof; c) The medical practitioner is employed by a practitioner who requires, as a condition of employment, that the fees be turned over to the employer; d) The medical practitioner has a contractual/salary arrangement or is employed by a governmental entity that requires, as a condition of employment that the fees be turned over to the governmental entity; e) The medical practitioner has a contractual/salary arrangement or is employed by a community mental health agency that is certified by the Department of Human Services under 59 Illinois Administrative Code, Ch. IV, Part 132 and is enrolled as a provider in the Illinois Medical Assistance Program; f) The medical practitioner has a contractual/salary arrangement or is employed by a Federally Qualified Health Clinic that is enrolled as a provider in the Illinois Medical Assistance Program. If at any time any of the conditions of this agreement are modified, the parties will immediately notify Healthcare and Family Services.

The parties acknowledge that false, inaccurate or incomplete information is grounds for cancellation of this alternate payee agreement or denial or termination of participation in the Medical Assistance Program and criminal and/or civil prosecution.

TO BE COMPLETED BY PRACTITIONER

_____	_____	_____
(Signature of Practitioner)	(Date)	(Provider #)
_____	_____	_____
(Printed Name)	(SSN)	(Individual Medicare #)

TO BE COMPLETED BY PAYEE

The payee certifies that the following owners/stock holders own 5% or more of the stock/shares in the payee's interest. If additional space is needed for names, please use separate page. If there is no information to disclose, write **NONE** on **PRINTED NAME** line. **This section MUST be completed for enrollment purposes and an entry is required.**

_____	_____	_____
(PRINTED NAME)	(SSN)	% OF OWNERSHIP
_____	_____	_____
(PRINTED NAME)	(SSN)	% OF OWNERSHIP

_____
(Signature of Payee Representative) Date

_____
(Print Name of Payee Representative) (Group Medicare #)

_____
(Name of Hospital, Professional School, Practitioner Owned Group Practice, FQHC, Community Mental Health Agency or Government Entity)

(PIN - Practitioner ID number required when using a group Medicare number)

(CHECK ONE)

☐ Hospital ☐ Government Entity

☐ Practitioner Owned Group Practice ☐ Professional School

☐ FQHC (Provider Number _____)

☐ Community Mental Health Agency (Provider Number _____)

_____
(DMERC #)

_____
(Tax #)

_____
(Telephone #)

_____
(Doing Business As name, if applicable)

_____

_____

_____
(Mailing address where payment is to be sent)

Check Box If practitioner Office Address should be changed to the Payee Address shown above.

This Alternate Payee Request is (Check One Box and Circle Affected Payee Number):

ADD CHANGE PAYEE 1 2 3 4 5 6 7 8 9